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ABSTRACT

The thesis of this paper is that the group therapy process is enhanced by the use of two or more therapists in the group. The three main roles in a group are: (1) facilitator, (2) focal member, and (3) observer. The use of an additional therapist affords the opportunity for therapists to assume the focal member role without loss of group control, that is without clients assuming the facilitator role defensively. Further advantages include: (1) the focus of authority is distributed over the several therapists, making it easier for each to participate as a real person, (2) group therapy trainees can participate without the full responsibility for the group and freely assume all three roles, (3) therapists who are present can observe the group interaction for research purposes and during post session analysis, check out their "inter-judge reliability," and (4) therapists of different orientations and styles can interact to their mutual enlightenment and individual clients can find, from among the available therapists, the one with whom each can communicate most effectively. (Author/KJ)

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A MODEL FOR CO-THERAPY IN GROUPS*

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The thesis of this paper is that the group therapy process is enhanced by the use of two or more therapists in the group. A tentative model or paradigm of the group will be presented in which co-therapists and clients function in a variety of roles which facilitate or impede group process. Finally, some propositions will be formulated from this model which can provide a research framework for generating testable hypothesis.

Erich Fromm has called the decade of the 1950's the "Age of Anxiety," and the 1960's the "Age of Isolation." Optomistically looking ahead, perhaps the 1970's can be called the "Age of Involvement." The growth of the group movement--the increasing formation of groups, both in clinical and non-clinical, social settings--seems to be a phenomenon in response to man's increasing sense of isolation. The malady of social hunger is growing and people increasingly experience the need for involvement, emotional intimacy, and caring. At the same time, they fear this very involvement and often cannot bring themselves to it.

It seems to me, then, that the immediate task, or process goal, of the group is to develop trust among its participants so they can shed their defenses and their status consciousness, modify their ambivalent, incongruent behavior, and share their lives with one another. The outcome, it

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is hoped, will be the transfer of the participants' learning to people outside the group with whom they must live. Let us analyze the group process, then, to see how these goals can be accomplished.

Structurally, the group consists of participants, some of whom have the assigned formal role or status of therapist and others the status of client, depending on their avowed purposes for participation. Functionally, however, group participants (including the therapist) assume the roles of facilitator, focal member, and observer. This is to say that at a given time, any participant can assume any of these three roles, but no participant can assume two roles simultaneously. Typically, however, the dominant role of therapists will be that of facilitator, and the dominant role of clients will be that of observer, and occasionally focal member. It should be noted, however, that therapists can also assume the role of observer and focal member, just as clients can assume the role of facilitator.

At this point, perhaps these roles should be more clearly specified:

1. facilitator: a participant in this role is attempting to aid a focal member to experience his feelings, understand them and communicate them to the group or to the facilitator. The facilitator may do this by initiating a communication to the focal member, by giving him immediate emotional feedback or by the familiar therapist techniques of reflecting, clarifying, interpreting, questioning, probing, etc. . . .

2. focal member: a participant in this role is the focus of attention of the group. This role is the reciprocal of the facilitator. The focal member has either by his own initiation, or by reason of the communication of a facilitator, expressed some thought or affect either verbally or non-verbally, to which the group responds by attending to him. He is expected to clarify or elaborate his first expression, to continue to share his experiencing, to let the group know "where he is at."

3. observer: participants who are not in the role of facilitator or focal member are in the role of observer. (The only other role is the non-functional role of non-participant, i.e., one who either psychologically or physically withdraws from the group). The

> observer is attending to the interaction of the facilitator and focal member. He is listening, thinking, feeling, but his communication, if any, is non-verbal. He may be "lost in his own data world. Frequently, he is feeling a strong sense of identification with the focal member and occasionally with the facilitator.

With these three roles in mind, then, let us look at the group process as it typically exists, i.e., the case of one therapist and six to eight clients. Figure 1 shows the dominant roles assumed by the participants. The therapist is the facilitator, and client number four is the focal member, while the remaining clients are observers. Figure 1-A represents the same situation, except that client number five is now the focal member. And finally, in Figure 1-B, the therapist becomes an observer, client 3, the facilitator, and client 7, the focal member. In this typical case of one therapist, a number of problems arise which can be more readily resolved by the use of additional therapists.

In both individual and group therapy, there is a trend, among therapists of most persuasions, toward greater involvement. In many cases this is not only seen as a theoretically defensable position, but also a growing expectation--even a demand--on the part of our clientele. How does the therapist become involved? How does be become a member of the group? How does he share his own person, unless it be by abdicating his control function as leader? A perennial problem in groups has been the problem of members challenging the authority of the therapist. Parenthetically, the challenge of authority so prevalent in our riot torn, and demonstration weary world is accurately reflected in the microcosm of the group. In the group, the relationship of the clients to the therapist is at issue. The challenge to his authority may come early in the life of the group, or late; it may take the form of an explicit confrontation, or more subtle forms

such as passive-aggressiveness, passive-dependency, displacement, or withdrawal. In any case, the issue is present, just as surely as it is in the life of every adolescent. If this authority is maintained rigidly by the therapist, he is in control, but minimally effective because of his vertical, distant, and impersonal relationship with the members. On the other hand, if he submits to the authority challenge and becomes "equalized" as it were, the therapist, or facilitator, function is taken up by other members of the group, often as a defense on their part from the threat of personal exposure. Another phenomenon in the group process has been noted by many therapists. This has been variously called the therapeutic potential of group members, and members taking on the therapist role. In the terminology of this model, it is referred to as the client assuming the facilitator role. Once trust has been established in the group, clients develop a genuine interest in helping one another, an interest in sharing in the therapeutic enterprise, which, initially is the concern of the therapist alone.

These two group phenomena, the challenge of authority, and the clients' growing interest in the facilitator role interact, such that the latter is the usual form of the former. This is to say that therapists' behaviors are modeled by clients, and they vie with therapists for the facilitator role, as a subtle form of the challenge of authority. It should be noted that the facilitator role can also be used for other defensive purposes by the non-self-disclosing client, or by the client who harbors negative feelings toward the focal member.

At this point, I will leave to your imagination the problems which arise in the typical case of one therapist as he tries to deal with these two

issues in group process. Let me proceed to the atypical case, that is, the use of co-therapists in groups. Figure 2 presents the case of two therapists and eight clients. Therapist 1 assumes the facilitator role and therapist 2, the observer role. Figure 2-A is the reverse with therapist 2, the facilitator. Figure 2-B is the case in which both therapists are observers. Figure 2-C is the case in which therapist 1 is the focal member and therapist 2 is the facilitator. Finally, Figure 2-D is the case in which client 8 is the facilitator, and therapist 2 is the focal member, while therapist 1 is an observer. (The numerous variations within each figure are evident).

Figures 2-C and 2-D introduce the therapist in the role of focal member. It is the opinion of this writer that unless the therapist at some time assumes the role of focal member, he will not become a person to the clients, and the authority challenge will not be explicitly raised and dealt with. If he assumes the role of focal member without a co-therapist, then the facilitator role is left in the hands of clients who, for reasons mentioned earlier, may assume the role for defensive purposes. Consequently, in order to become real persons and to model ideal interaction, the two therapists can alternate the facilitator-focal-member roles (see Fig. 2-C). Or if client 8 (see Fig. 2-D) in the judgment of therepist 1 is defensively in the facilitator role, then therapist 1 can assume it in relation to therapist 2, or can confront client 8. In this case, without therapist 1, therapist 2 would be perceived as avoiding the focal member role for defensive reasons.

To summarize, then, the use of an additional therapist affords the opportunity for the therapists to assume the focal member role without loss of group control; that is, without clients assuming the facilitator

role defensively. It is proposed that under these conditions, clients' relationship to the authority can be most effectively resolved and clients' adaptive use of the facilitator role can be achieved.

Extending this model to include more than two therapists affords further advantages. In addition to the possible interactions described in Figure 2, Figure 3 presents the case of each therapist assuming one of the three roles. Figure 3-A, using four therapists, suggests the possibilities of co-participation in a given role.

The opportunities for co-participation in a given role are by no means exclusive to the situations of multiple therapists or co-therapists. Earlier, it was stated that any participant could assume any role, but no participant could assume two roles simultaneously. This does not exclude the possibility of a participant sharing a role with another participant, which, indeed is the case with regard to the observer role. But in the case of a single therapist, not only is he limited in his use of the focal member role, as has been stated earlier, he is also limited in his sharing of the facilitator role if clients who assume the facilitator role are doing so defensively. Finally, clients, as well as therapists, can co-participate in the focal member role. For example, two clients who identify with and support each other are often confronted by a third client. Or, again, in the challenge of authority, both therapists are confronted by clients.

But let us return to the statement that extension of the model to include more than two therapists affords further advantages. One advantage is that the locus of authority is distributed over the several therapists, making it easier for each to participate as a real person. Another is that group therapy trainees can participate without the full-responsibility for the group and freely assume all three roles. A third is that therapists

who are present can observe the group interaction for research purposes, and during post-session analysis, check out their "inter-judge reliability." Finally, therapists of different orientations and different styles can interact to their mutual enlightenment and individual clients can find, from among the available therapists, the one with whom each can communicate most effectively.

The growing length of this paper prohibits any systematic treatment of the possible disadvantages of additional therapists in the group. There are, I am sure, many. In summary, let me state a few propositions generated from this model which can provide a partial framework for research:

1. The degree to which a client assumes a dominant role, to the exclusion of other roles, will be inversely related to progress or improvement for that client.

2. The degree to which a therapist distributes his participation over the three roles will be directly related to his effectiveness.

3. The degree to which all participants assume all three roles will be directly related to overall effectiveness of the group.

4. Groups which are led by a single therapist are less effective than groups which are led by two or more therapists, because of the flexibility of roles available to the therapist.

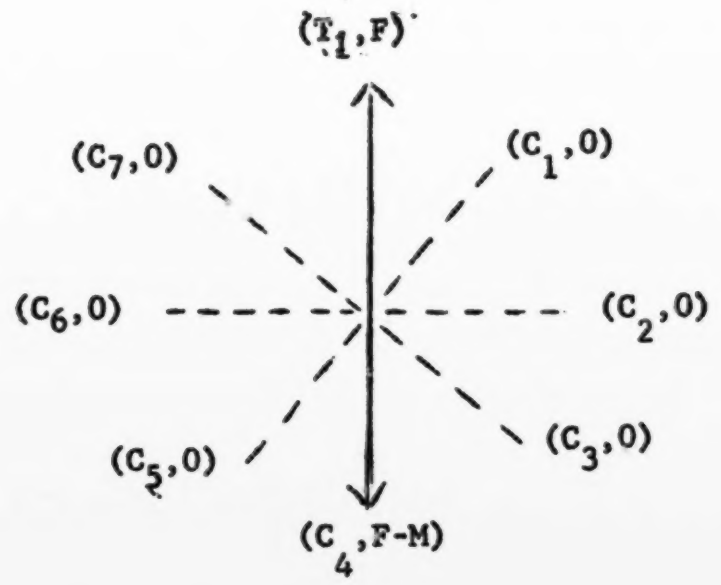
5. The challenge of authority will be a more explicit issue and will be resolved more readily in groups with co-therapists than in groups with a single therapist.

6. The defensive use of the facilitator role by clients will be less frequent in groups led by co-therapists than in groups with a single therapist.

7. In groups led by co-therapists, clients will perceive the therapist as more of a participating member, than in groups with a single therapist.

8. Supervisors will rate trainees as having improved more if they have functioned as co-therapists, rather than have led groups as single therapists.

FIGURE 1
Dominant Roles of Group Participants in
The Typical Case of One Therapist



Status		Poles
T_1	- Therapist	F - Facilitator
		F-M - Focal Member
C_1	- Clients	O - Observer
C_2	"	
.	"	
.	"	
.	"	
C_7	"	

Variations:

Figure 1-A

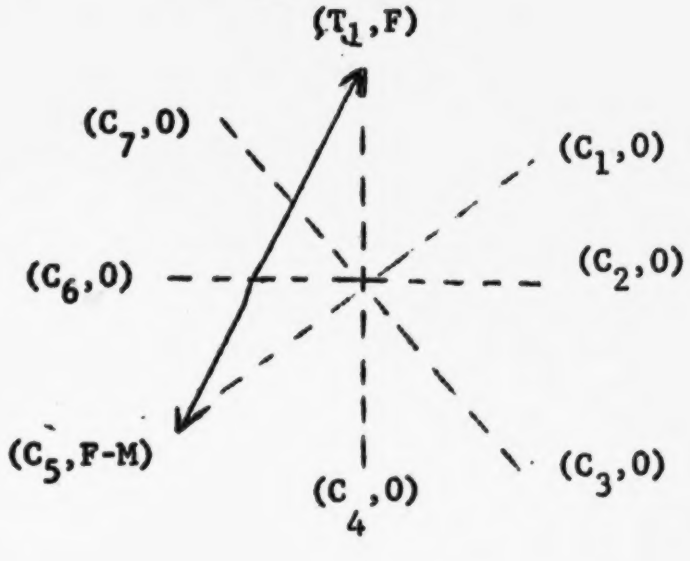


Figure 1-B

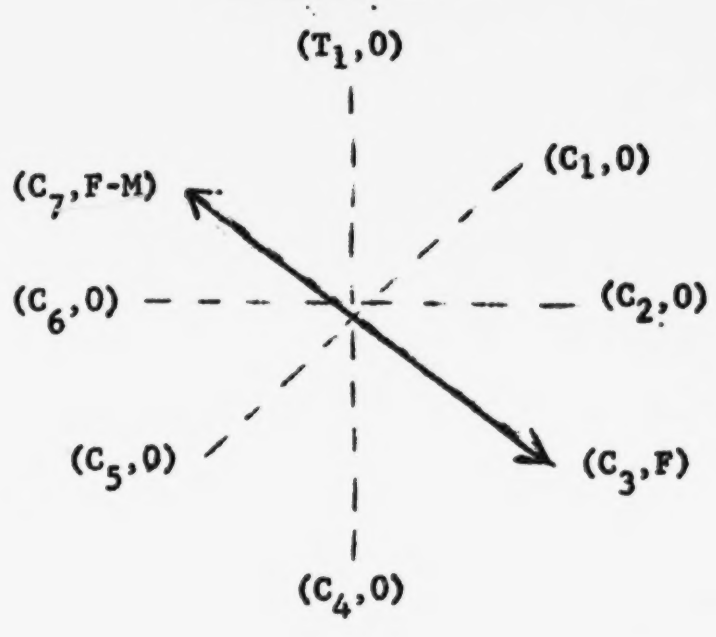
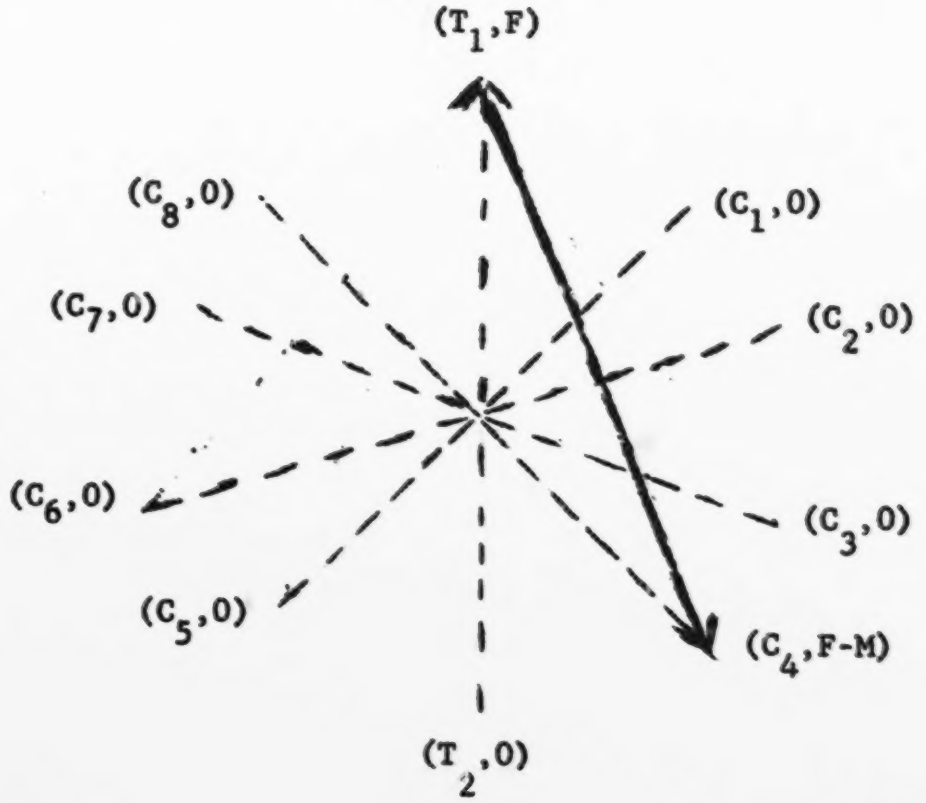


FIGURE 2
Roles of Group Participants in The Case of Co-Therapists



Variations:

Figure 2-A

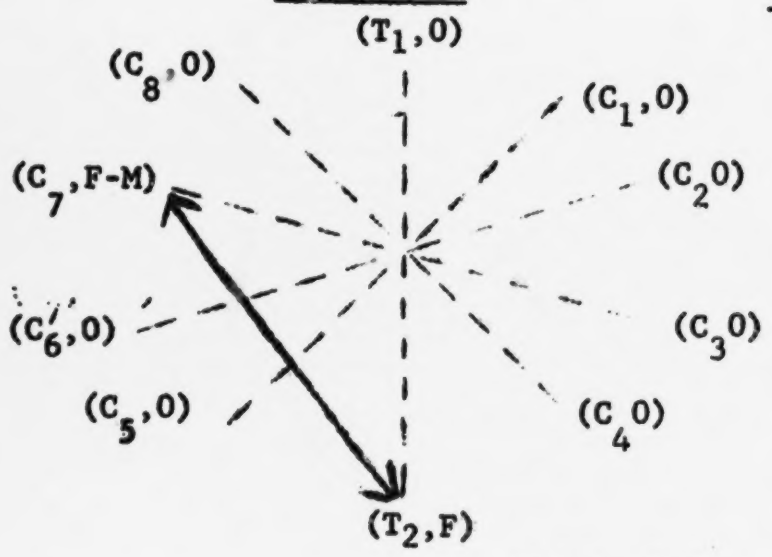


Figure 2-B

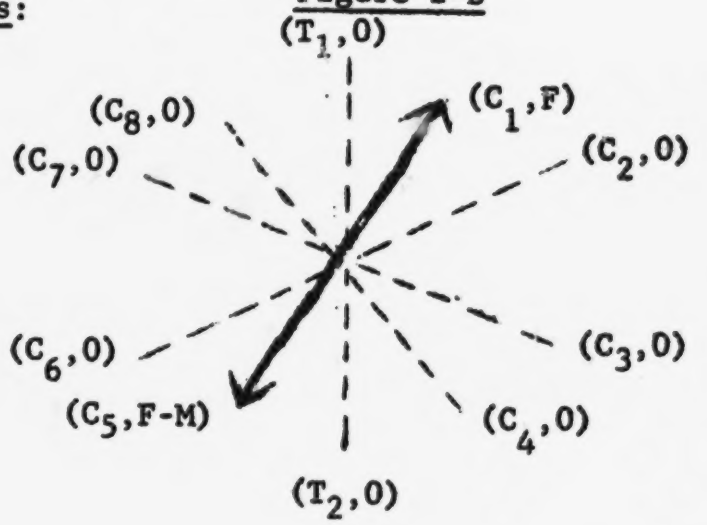


Figure 2-C

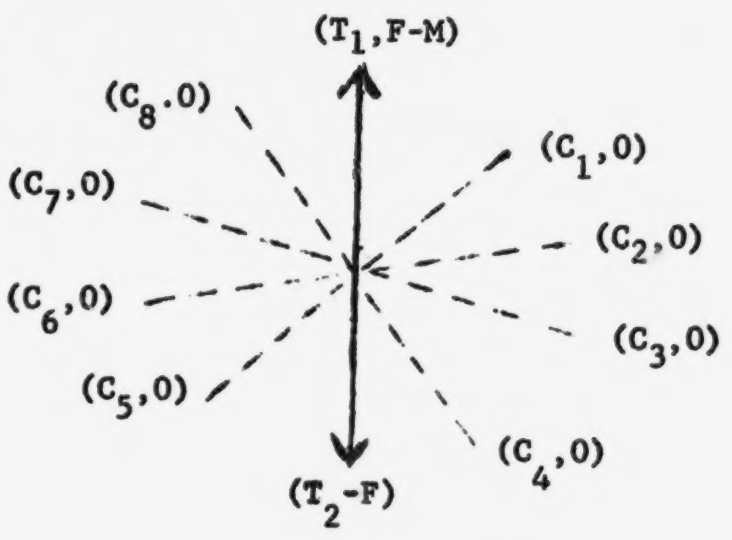


Figure 2-D

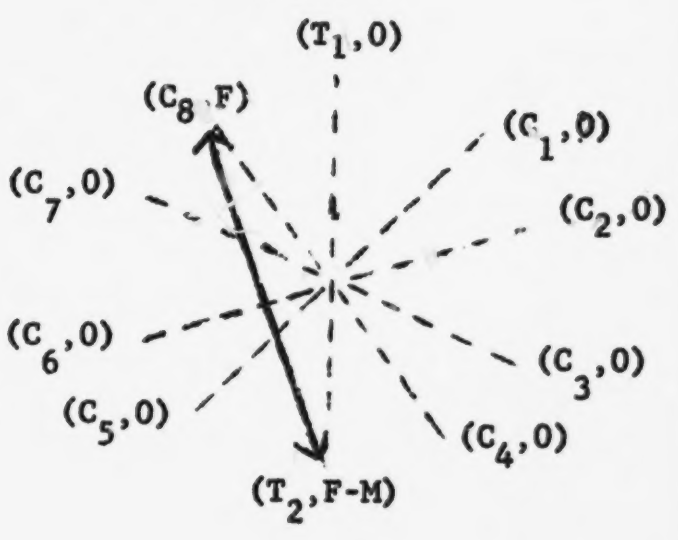


Figure 3
The Use of Three Therapists in The Group

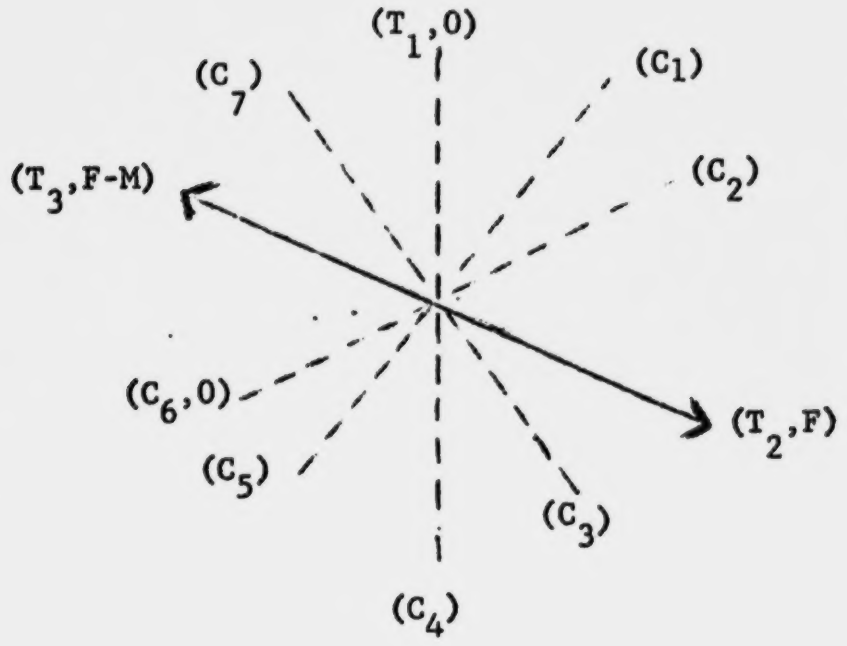


Figure 3-A
Use of Four Therapists in The Group